04-303

USAID GRANT AGREEMENT NO. 497-0008.01

AMENDMENT NO. 3

STRATEGIC OBJECTIVE GRANT AGREEMENT

BETWEEN THE

REPUBLIC OF INDONESIA

AND THE

UNITED STATES OF AMERICA

FOR

PROTECTING THE HEALTH OF THE MOST VULNERABLE WOMEN AND CHILDREN

Certified to be a true copy of
the original signed by

James Hope, Deputy Program Director
October 11, 2002

Date: September 21, 2001

This AMENDMENT No. 3 is entered into between the REPUBLIC OF INDONESIA ("Grantee") and the UNITED STATES OF AMERICA, acting through the U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT ("USAID").

WHEREAS, the Grantee and USAID, entered into a Strategic Objective Agreement for Protecting the Health of the Most Vulnerable Women and Children dated August 13, 1999, which was amended on May 31, 2000, and June 6, 2000, whereby USAID agreed, subject to the availability of funds, to grant to the Grantee not to exceed Forty-two Million One Hundred Eighty Two Thousand and Two Hundred Fifty Six U.S. Dollars ($42,182,256); and

WHEREAS, the Grantee and USAID desire to further amend the Grant Agreement to provide an increment of USAID grant financing in the amount of Twenty-Seven Million, Seven Hundred and Twenty Two Thousand U.S. Dollars ($27,722,000) and to make other changes in the Program Description;

NOW, THEREFORE, the Grantee and USAID hereby agree as follows:

1. Page 2, SOAG dated August 13, 1999. Delete the following paragraph in its entirety: "WHEREAS, USAID's Washington headquarters have created a regional project entitled, Accelerating Economic Recovery in Asia (Project No. 498-0001), through which additional resources are being made available to support the objectives contained in this agreement".

2. Article 2, Section 2.2 Results. Para (a) is hereby deleted, substituting therefor the words, "policy environment for reproductive and child health is improved." Para (b) is hereby deleted, substituting therefor the words, "health service systems are strengthened to improve access, quality and sustainability." Para (c) is hereby deleted, substituting therefor the words, "women, families and communities are empowered to take responsibility for improving health."

3. Article 3, Section 3.1 (a) The Grant: Current Increment. First sentence is revised by deleting the words "Forty-two Million One Hundred Eighty Two Thousand and Two Hundred Fifty Six United States Dollars $42,182,256)" to read "Sixty-Nine Million, Nine Hundred and Four thousand and Two Hundred Fifty-Six U.S. Dollars ($69,904,256)".

4. Article 3, Section 3.1 (b) Total Estimated USAID-Contribution. First sentence is revised by deleting the words "Seventy Million U.S. Dollars ($70,000,000)" to read "Eighty-Six Million U.S. Dollars ($86,000,000)".

5. Article 3, Section 3.2. Grantee Contribution. Last sentence is revised by deleting the words "a quarterly" to read "an annual".

6. Article 4 (a) The Completion Date. First sentence is revised by deleting the words "September 30, 2003," to read "September 30, 2005".

7. Article 6, Section 6.3 is amended by adding the following sentence to the end of the paragraph: "In the event of ambiguity Section B.4 of Annex 2 governs".

8. Article 6, Section 6.4 is deleted in its entirety and the following text is substituted in lieu thereof:

Section 6.4. Taxation of implementing partners. The government agrees, pursuant to Section B.4 of Annex 2, any individual, contractor, grantee or other organization carrying out activities financed by USAID under this Agreement shall be exempt from income taxes, with the exception of non-nationals. The term "national" refers to organizations established under the laws of the Grantee and citizens of the Grantee, other than permanent resident aliens in the United States. In the event of ambiguity, Section B.4 of Annex 2 governs.

9. Article 6, Section 6.7 is added as follows:

"Section 6.7. Core Values. The parties agree that five core values shall govern the objectives, strategies, results, and activities described in this agreement. The five core values are: customer focus, managing for results, empowerment and accountability, teamwork and participation, and valuing diversity.

(a) Customer Focus. All activities under this agreement will focus on customers. In this context, "customers" are the people of Indonesia who benefit from the achievement of the Strategic Objective:

community-based organizations, civil society organizations, national and local Parliaments, and national and local government units. Special attention will be given to the socially and economically disadvantaged women. To the maximum extent possible, customers will be involved in all aspects of the design, implementation, monitoring and evaluation of activities;

(b) Managing for Results. Activities undertaken under this Agreement must have tangible, measurable results. Any activity that does not achieve the desired result(s) will be modified, replaced or discontinued, and/or the implementing agency may be replaced. Evaluation of the impact of the activities will not focus on the activities per se or their output (such as the number of persons trained), but on the impact that these activities have had on the lives and well-being of the customers;

(c) Empowerment and Accountability. To achieve results described in this Agreement, individuals involved in the implementation of the activities must be given the authority to make decisions, and should be held accountable for the results of their decisions and actions;

(d) Teamwork and Participation. Efforts to achieve the Strategic Objective will be undertaken jointly by all the partners involved, at all levels, in close collaboration, in a participatory fashion, and in a spirit of teamwork. Roles and responsibilities are described in Annex 1, Revised Amplified Description, Section V.A-D; and

(e) Valuing Diversity. Efforts to achieve the Strategic Objective will take into account the diversity of views, experience, skills, capabilities, and beliefs of all the partners involved regardless of ethnicity, nationality, gender and organizational status."

10. Article 6, Section 6.8 is added as follows:

"Section 6.8. Evaluation. The parties agree that, if deemed necessary and reasonable, the activities undertaken to achieve the Strategic Objective may be evaluated before the Completion Date. If the decision is made to conduct such an evaluation, the Parties will jointly decide on the scope, mechanism and timetable of the evaluation."

11. Annex I, Amplified Description, is deleted in its entirety and Annex I, Revised Amplified Description, dated September 2001 is substituted in lieu thereof.

12. Table I Revised Budget Summary of the Grant Agreement is hereby deleted, substituting therefore the Table I Revised Financial Plan (September 2001) attached as Attachment A to this Amendment No. 3.

Except as amended herein, the Grant Agreement as amended is unchanged and remains in full force and effect.

IN WITNESS WHEREOF, the Republic of Indonesia and the United States of America, each acting through its duly authorized representative, have caused this Amendment No. 3 to be signed in their names and delivered as of the day and year first above written.

REPUBLIC OF INDONESIA

Dr. Achmad Sujudi, MHA
Minister of Health

Sri Redjeki Sumaryoto, SH
State Minister for
Empowerment of Women

Drs. Lalu Sudarmadi, MPIA
Principal Secretary
National Family Planning
Coordination Board

UNITED STATES OF AMERICA

9/30/01

Desaix B. Myers
Mission Director
USAID/Indonesia

Attachment A

Table 1
Protecting the Health of the Most Vulnerable Women and Children
USAID Grant Agreement No. 497-0008.01
Amendment No. 3
Revised Financial Plan (September 2001)

Funding Category	Total (USD) Life of Program Funding*	USAID Obligations through FY2000			USAID Obligations This Amendment Grant No. 497-0008.01 (USD)	Total Obligations to Date (USD)**
		USAID/Indonesia Grant No. 497-0393 (USD)	ANE Bureau/AERA Project No. 498-0001 (USD)	USAID/Indonesia Grant No. 497-0008.01 (USD)		
a. Family Planning	18,000,000	1,700,000	0	5,850,000	5,400,000	12,950,000
b. Maternal, Child Health and Nutrition[1]	43,000,000	6,700,000	6,500,000	16,632,256	11,072,000	40,904,256
c. HIV/AIDS and Infectious Disease[2]	16,000,000	0	0	4,200,000	7,035,000	11,235,000
d. Complex Emergency Health Responses[3]	4,000,000	600,000	0	0	2,300,000	2,900,000
e. Decentralization[4]	5,000,000	0	0	0	1,915,000	1,915,000
Sub-total	86,000,000	9,000,000	6,500,000	26,682,256	27,722,000	69,904,256

[1] This category merges the old 'Maternal and Neonatal Health' and 'Child Health and Nutrition' categories
[2] This category replaces the old 'HIV/AIDS' category to include other infectious diseases, primarily malaria and TB
[3] This category replaces the old 'Crisis Monitoring and Surveillance' category
[4] This is a new category under the SOAG amendment
Funding for the 'Program Management, Evaluation' category has been distributed between the other categories
* Subject to the availability of funds.
** The GOI has agreed, pursuant to Section 3.2, to provide in-kind contributions and report on those contributions on an annual basis.

ANNEX 1

REVISED AMPLIFIED DESCRIPTION

Protecting the Health of the Most Vulnerable Women and Children

USAID/Indonesia

Revised September 2001

ANNEX 1. AMPLIFIED DESCRIPTION PROTECTING THE HEALTH OF THE MOST VULNERABLE WOMEN AND CHILDREN

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ANNEX 1

REVISED AMPLIFIED DESCRIPTION

PROTECTING THE HEALTH OF THE
MOST VULNERABLE WOMEN AND CHILDREN

I. Purpose

This Revised Annex provides an amplified description of the USAID/Indonesia Strategic Objective: Protecting the Health of the Most Vulnerable Women and Children, the type and scope of activities to be undertaken for this program, and the results to be achieved with the funds obligated under the Strategic Objective Agreement (referred to as the Agreement). Nothing in this Annex shall be construed as amending any of the definitions or terms of the Agreement.

II. Background

Indonesia is in the midst of multiple transitions – constructing new political and economic systems and reconstructing social relationships to ensure greater equity across regions and between classes. When completed, however, Indonesia's transition will constitute a remarkable shift in the shape and texture of Indonesian political and economic governance. In the health sector, the transition is marked by many people who have been forced into near-poverty. Lowered incomes have made health services unaffordable, and budget constraints have reduced the government's ability to provide services. Families now delay health care, increasing morbidity and mortality. Increased poverty has significantly worsened nutritional status and health of vulnerable groups, particularly women and children. HIV/AIDS has a foothold in Indonesia and the potential to spread rapidly due to migration patterns and the growing numbers of women and men engaging in commercial sex. Poorly managed decentralization threatens a decline in access to and quality of services.

In 1998, USAID developed a country strategy in response to the economic crisis. In 2000, when the economy appeared to be stabilizing and showed signs of improvement, USAID revised the country strategy again to focus on the principles of support for reform to broaden the economic transition and strengthening the capacity of key institutions to meet the priority needs of the Indonesian people. USAID's Strategic Objectives for the current country strategy are broader in scope than they previously had been, and provide a mechanism for ensuring that activities work together toward a common purpose and contribute to specified objectives.
The program described herein provides a comprehensive articulation of the synergistic

relationships among all activities supported under USAID's Strategic Objective of Protecting the Health of the Most Vulnerable Women and Children within the context of USAID's current country strategy 2000.

A. Problem: Impact of the Current Political and Economic Situation on Health Status and Health Care

A healthy population is a critical pre-requisite for building a democratic and prosperous Indonesia. Studies suggest that infant mortality, a good indicator of the overall quality of life, correlates strongly with political instability and slow socioeconomic development. In Indonesia, long-standing progress made in improving health has been severely undermined by the economic crisis. New political imperatives, such as decentralization, threaten the ability of the GOI to ensure that the health needs of its growing population are met.

Indonesia has achieved tremendous progress in reducing population growth and child mortality since the late 1970s. This progress was in large part due to strong, centralized, political commitment to reducing fertility and under-five child mortality. Nevertheless, the population is still growing at a rate of 1.7 percent year, and maternal and neonatal mortality rates are among the highest in the region. Under the new decentralization laws, 249 regencies and 65 municipalities will absorb responsibility for planning, financing and managing health and family planning programs. USAID will provide critical assistance to the government in this process: to clarify responsibilities at central, provincial, and district levels; to garner commitment of local governments to invest in primary health care; and to develop standards for accountability and sustainability. The new era of civic participation provides an opportunity for the enhanced involvement of families and communities to take responsibility for improving their own health.

Poor women and children face the greatest threats to their health and typically have the smallest voice in health care decision making. High levels of malnutrition and micronutrient deficiencies threaten the survival and the intellectual development of an entire generation. Indonesian women are dying in childbirth from having too many children, too closely spaced, and from lack of access to trained birth attendants. The unacceptably high maternal and neonatal mortality rates are indicative of the low status of women and serious capacity problems within the health system. HIV/AIDS prevalence remains low in official reporting, but transmission is increasing steadily among high-risk populations in large cities, port areas, and highly traveled routes. Tuberculosis (TB) is one of the leading causes of morbidity and mortality. Indonesia ranks third among countries with the highest burden of TB worldwide. TB threatens the most vulnerable and undermines progress against poverty by taking lives in their prime earning years. Malaria is again epidemic in parts of Central Java and threatens to reemerge with dire economic and human consequences if not contained. Investments in preventive health care for family planning, maternal/child health and nutrition, HIV/AIDS, infectious diseases, specifically, TB and malaria, have large payoffs in reducing excess morbidity and mortality. Health is a central feature of any poverty alleviation program, and is a crucial building block for a productive population, a robust

economy, and an equitable society. The ability of the GOI to meet the health care needs, demands and expectations of its population is an imperative for improved health status.

The impacts of the recent crisis on the determinants of health status are the following:

- Reduced food consumption has resulted in severe nutritional and micronutrient deficiencies, particularly for women and children under age five.
- Reduced reliance on modern health care has resulted in higher severity of illnesses and disease.
- Reduced levels of education attainment have resulted as family members (including children and adolescents) have struggled to generate income.
- School enrollment levels have decreased so the educational attainment for a generation is likely to fall. This can have long-term consequences on the health status because maternal education has been found to be a strong predictor of reduced fertility as well as the health status of children.
- Increased levels of high risk behavior, such as engagement in commercial sex, as a necessity prompted by unemployment. Increased participation in the commercial sex industry can lead to increased incidence of sexually transmitted diseases.

While some recovery from the crisis has taken place, further crises have developed since 1998, mostly as a result of shifts in the political situation. The secession of East Timor in 1999, secessionist troubles in outlying provinces, hostilities between religious groups in the Moluccas islands and ethnic violence in Kalimantan have resulted in a new problem for Indonesia – internally displaced persons (IDPs) and refugees (in the case of Timor). There are now an estimated 1.2 million IDPs in both urban and rural areas of the country.

IDPs and refugees are highly susceptible to infection and diseases as their health and nutritional status is very often far from satisfactory. This is because 1) displaced people often belong to the poorest segments of population and have consumed a diet that is inadequate due to limited purchasing power; 2) when they arrive at camps for IDPs, they are already in poor health and it may have taken several weeks to reach the destination; 3) their coping mechanism is diminished and exposure to unsanitary conditions and poor diet renders them more susceptible to infectious diseases, particularly when they are micronutrient deficient.

The economic crisis has also had a severe impact on *health care* -- the health sector's ability to perform its mission. There is a rapidly widening gap between household resources and government resources available to purchase and provide health care, and the resources that are needed to address the increased health care needs of the population. Moreover, the current health care crisis is being aggravated by sudden outbreaks of diseases and widespread social violence in

certain provinces. Finally, in response to the economic and political crisis, the health sector in Indonesia is undertaking a major decentralization reform effort to improve the efficiency of resource allocations and to empower local governments. Given the widening resource gap, as well as sudden political changes, the ability of the public and private sectors to address the health care crisis has been curtailed severely.

- Public sector health care.

The economic crisis has compromised the ability of the Government of Indonesia to finance the health sector. Health expenditure as a percentage of Gross Domestic Product, was already low at 1.6% before the crisis began. As a result of the economic crisis, the Government's allocated budget for health and family planning was reduced significantly. Both Indonesia's reliance on imported pharmaceuticals, materials and equipment, and the devaluation of the rupiah have led to at least a three-to-five-fold increase in health care costs. There are decreasing resources to improve quality at all levels of the health care system. Declining budgets have forced cutbacks in routine service delivery operations, such as training, travel and transportation, provision of medical supplies, supervision, and program monitoring. The public sector needs to monitor the effects of the crisis carefully in order to target scarce resources and to design effective interventions.

Decentralization is a key reform issue for all sectors, including the population, health and nutrition sector. The economic, political, and humanitarian situations provide an unprecedented opportunity for USAID to assist the Government of Indonesia to advance the decentralization process now underway. The Ministry of Health and Social Welfare is committed to strengthening institutional, management, leadership and technical capabilities of provincial and district health offices and facilities.

- Private sector health care.

The economic crisis had a severe impact on the viability of the private health care sector. Private sector investment and revenues diminished, while the cost of import-dependent drugs and supplies increased. Lower purchasing power, resulting in a lower demand for private services among certain income groups, as well as higher costs of inputs necessary to provide medical care and the unavailability of investment, all threaten the survival of the private sector. At the same time, as a result of the nationwide political and democracy reform efforts, there is also an unprecedented opportunity to improve and expand local non-governmental organization involvement in the management and delivery of health services at the community level.

Considered together, the *health crisis* and the *health care crisis* form a widening gap between reduced resources and increased need for health care, creating an increased burden of disease.

B. Strategic Objective and Intermediate Results

The Strategic Objective of USAID's health program continues to be to protect the health of the most vulnerable women and children.

Over the past two years, the program was concerned with monitoring the effects of the crisis on nutrition and health, and on preserving the delivery of essential preventive health services to the most vulnerable women and children. As Indonesia recovers from the economic crisis and as democratization takes root, USAID's health strategy will evolve into a three-pronged approach that supports the supply and demand aspects of health within the context of decentralization. First, the strategy will improve the enabling environment in accordance with health reforms underway. Second, the strategy will strengthen capacity and commitment of the GOI and the private sector, particularly at the district level, to meet the needs of the people. It is at this level that family planning and health services will be delivered or not, where quality standards will be achieved or not, and where clients will decide to use these services or not. Third, the strategy will help individuals and communities to participate more fully in building a healthy Indonesia – by deciding what quality health care means to them, by learning to demand these services from locally elected representatives, and by improving their own behaviors. There is an evident need for capacity building, the need to bridge the gap between popular expectations and the ability of the government to meet those expectations, and the need to facilitate the process of decentralization. USAID's health strategy directly addresses each of those needs.

To achieve the overall Health Strategic Objective, USAID will undertake activities to ensure the following Intermediate Results (IR), the activities required to achieve results that lead to the Strategic Objective:

- IR1: *Policy environment for reproductive and child health, HIV/AIDS and Infectious Diseases is improved*

Political and economic reforms create tremendous opportunities for improving the health of women and children, but they also present potential threats. Highly centralized systems used in the past to implement local programs may no longer exist. It will be critically important to ensure that financial and human resources at the local level are available for basic preventive health services, and that local authorities support the need for family planning, maternal/child health and nutrition, HIV/AIDS and infectious diseases. As the Indonesian society and government increasingly recognize the rights of women, family planning must be repositioned from a top-down, demographically driven imperative, into a broader framework of reproductive health that covers women's health and women's empowerment. At the same time, attention must be focused on reducing the threats to a woman's survival in childbirth and on preventing the spread of HIV/AIDS and the re-emergence of infectious diseases, particularly TB and malaria.

- IR2: *Health service systems are strengthened to improve access, quality and sustainability*

Improvement in the health status of women and children is dependent on the availability and use